

U.S. NAVY MEDICINE

January 1982



Interagency Cancer Research

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Focus on Family Advocacy

CDR Eli Breger, MC, USNR

Patterns of Abuse and Their Psychological Consequences for the Child

Part two of a three-part series

Can children be abused in ways other than physical? Yes, indeed! Abuse of children can take a multitude of forms and occur simultaneously. The description of the "battered child" forced professionals to face and deal with what had been an avoided area of familial disturbance. It also provided the long needed opening for studying other less striking mistreatment. Moreover, it gave rise to the concept of "child advocacy"—the idea that a young child, because of limitations in intellectual development, language, experience, and legal standing, needs a guardian and protector to defend his physical and emotional well-being. Every state in the Union now has statutes making such advocacy mandatory and protecting vulnerable or victimized children. The Child Advocacy Program of each command is a Navywide policy with a plan of action to insure our children's protection and to help families overcome problems which led to the abuse.

Physical abuse, when parents actively, consciously, and dramatically injure their child, is the form with which we are most familiar. Let us explore other expressions of abuse to children.

Physical neglect of a child results from parent failure to provide the basic physical necessities of life such as proper nutrition, warmth, and cleanliness. Such inattention frequently reflects profound immaturity in the parent or mother's emotional difficulties resulting in her energies being deflected away from the child. In either case, the neglect is passive and unintentional. The children may show poor weight gain or wasting, paleness, enlarged abdomen, severe diaper rash, skin and eye infections and, at a later age, learning disabilities. In past times lack of food due to extreme poverty was a common culprit, but this is unusual in our present society.

Emotional abuse is characterized by willful and consistent heaping of anger, hostility, shame, and rejection on the child, thereby emotionally damaging development. All parents get angry at their children at times and frequently lose control over these angry emotions. Children who basically feel loved can deal with these

occasional outbursts without erosion of their confidence. Emotionally abusive parents essentially reject their child with widespread and incessant harshness, thereby damaging his fragile self-esteem.

Emotional neglect occurs when parents ignore their child's need for holding, cuddling, and other demonstrations of their love and caring. Without this nurturant behavior, an infant's physical, emotional, and intellectual development may be stunted, especially if the child is vulnerable and both parents are indifferent. Such parents are not usually willful and intentional in their disregard. Rather, their behavior reflects such problems as extreme youthfulness and immaturity, self-absorption due to depression, or poor contact with reality because of a major psychiatric disorder.

Failure to thrive is an extreme form of emotional neglect seen in infants soon after birth. They demonstrate poor growth, particularly in weight. Physicians suspect major disease of the heart, kidney, or nervous system. However, negative medical findings coupled with dramatic weight increase when the child is hospitalized and cared for by others clarifies the cause. This failure to thrive reflects

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the lack of establishment of the primary child-mother emotional bond critical to growth and development.

Sexual abuse of children is far more widespread than imagined. More cases are being reported and more knowledge is emerging. The abuse ranges from casual stimulation to incest. The father abusing his oldest daughter is the most common form. It usually begins when she is of school age and continues with regularity until adolescence, at which time the increasingly independent, rebellious daughter, with the encouragement of friends, exposes her father. Frequently, one observes the mother, who had functioned as an adequate sexual partner early in the marriage, bow out of this role for various reasons, looking aside while her sexually deviant husband shifts his attention to the daughter. Although such incestuous activity takes place in the home when other members are out or asleep, in time other family members suspect but deny it, look aside, and lock the secret within the bosom of the clan. The young girls are not only abused by their fathers but are left unprotected by their mothers. It may, indeed, be viewed as a double abuse.

What are the psychological consequences of abuse for the child?

This issue has received little attention, and then only recently. The energy of professionals working in the field has mainly been devoted to crisis intervention, ministering to the child's medical needs, and working toward strengthening parental relationships, thereby safeguarding the child from further injury. The consequences considered clearly related to the sustained physical injury, i.e., the effects of brain injury on intelligence, speech, and motor skills. The consequences of abuse on personality and emotional development were not often considered. Measurement of these changes is more subtle, difficult to detect, and often take considerable time to manifest. Yet, these effects are vitally important if we are

to protect these children from growing up with serious problems including the strong likelihood of their becoming abusive parents.

It is likely that many abused children weather the storm and lead relatively normal adult lives. After all, other life traumas are successfully incorporated into the personality. It is not as if the insult leaves no mark at all, but rather it is managed and put to rest.

Physical abuse will likely cause lasting problems when:

- there is frequent, long-term, and intense abuse before stabilization at home is accomplished;
- the child is young and the development of basic trust and security is hampered; and when
- other negative familial features such as physical and emotional neglect and spouse abuse are present.

When one closely monitors the development of children physically abused in a serious and prolonged fashion, the following developmental problems usually emerge. Developmental consequences of the other forms of abuse have been studied in varying depths with indications that many of their consequences fall into the same patterns of those following physical abuse:

- **Impairment of the infant's ability to develop a deep trusting love tie to mother.** Without this bond the scene is set for shallowness and inconsistency in future interpersonal relationships markedly hindering the individual's ability to maintain friends and marriage.

- **Angry and aggressive behavior.** To be raised with anger and aggression predisposes the child to react similarly and development of self-control over all forms of impulsive behavior is impaired. Successful socialization is hindered and the child tends to identify with the abusing parent incorporating that behavior into his own repertoire. This is particularly so

if the abusing parent has the same sex as the child, and boys, by their nature, are more so inclined. The abused child becoming an abusing parent has its developmental roots in such a process.

- **Inner fear and submissive docile behavior.** Anger and aggression, however, are not absent—they are kept under wraps and expressed in a rageful fantasy life which may become externalized in self-directed harm such as accident-prone injuries and suicidal attempts.

- **Psychic scars.** The emotional trauma of severe and protracted battering leaves a psychic scar. Without conscious realization the child seeks to relive the abusive experiences by setting up situations that bring aggression against himself. Strange as this may seem, it is not uncommon in the repertoire of human behavior. It may make sense when one views it as an individual's attempt to symbolically relive the bad experience so as to cope with it in a stronger, less helpless fashion.

- **Impairment of how the child views himself.** Low self-esteem, poor self-image, and diminished confidence are most often present. Should physical deformity result from the batterings, these feelings are inevitable. Emotional abuse and rejection by parents also intensify the impairment because the feeling of parental love is vital for the feeling of self-love and acceptance.

- **Academic difficulties of all types.** These follow naturally where the abuse has caused brain damage. In other cases, the emotional and personality difficulties affecting attention, preoccupation, confidence, and impulse control adversely affect the learning process and socialization requirements of the classroom setting.

- **Depression and psychosomatic disorders reflecting inner tension.** These will be present in those adults who, as children, responded to the abuse with constraint, withdrawal, and apathy. As children they ap-

peared to be doing well as they were quiet and well-behaved, but their hidden depression takes its toll in adult life.

Abused children need attention and careful monitoring during their development. Because of limited

staffing, professional services are presently hard pressed to provide protection for the child and bring stability to the home when abuse erupts. We look forward to the day, hopefully not long off, when attention and services will adequately be

afforded to these victims of abuse during their developing years and beyond.

"A fertile field, when neglected, will produce nothing but weeds and thorns." No known author □

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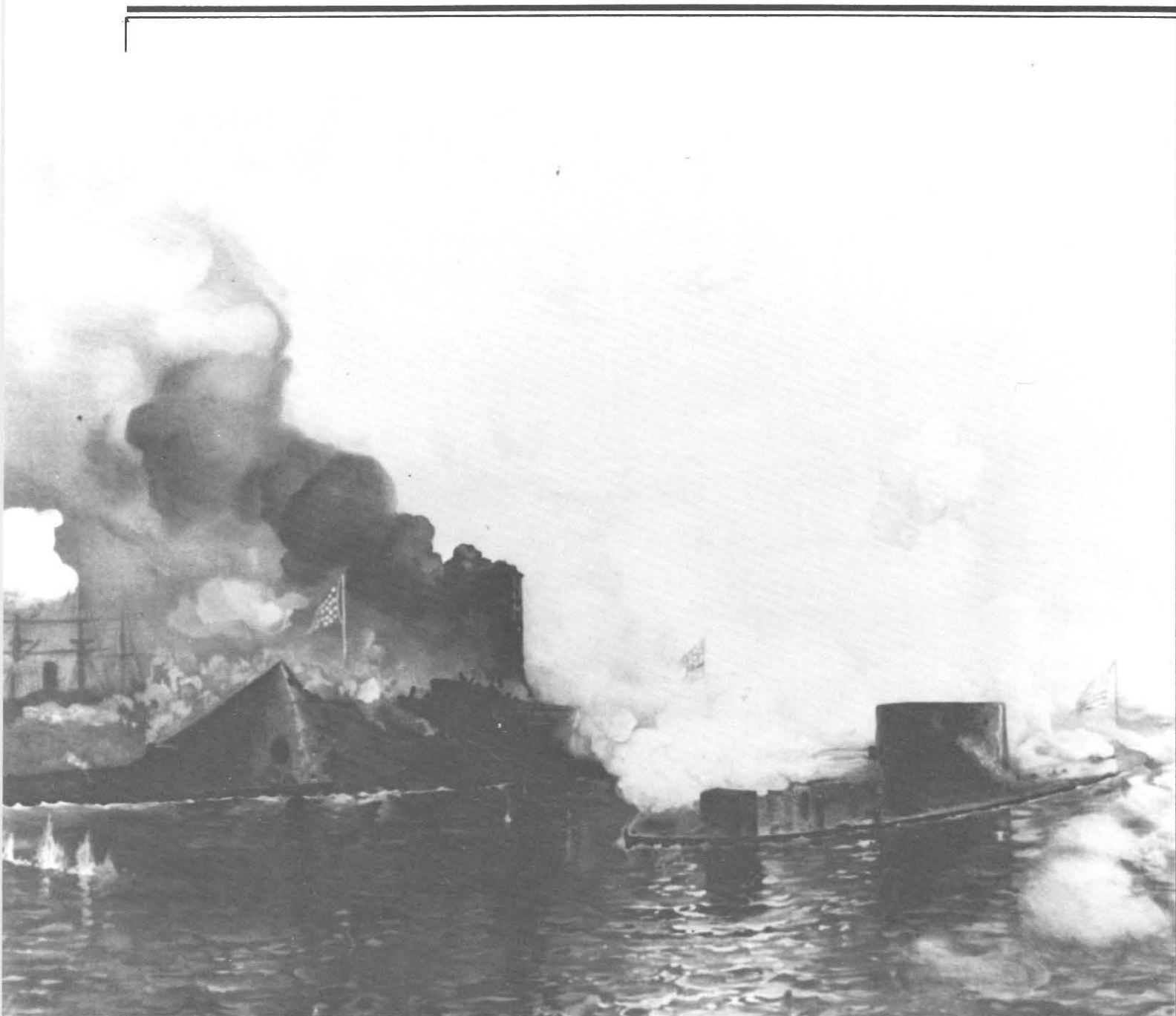
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USS Monitor vs. CSS Virginia (formerly USS Merrimack), 9 March 1862.

Treating the Wounded Aboard USS Monitor 1862

**United States Steamer Monitor,
Off Fortress Monroe, March 11, 1862.***

Sir: I have the honor to report to your department the casualties that occurred on board during the action with the rebel steamer Merrimack on Sunday, March 9. The engagement began at 8:30 a.m., but no injury was experienced by either officers or crew until 10 o'clock. At this hour precisely Mr. Stodder, first master, (volunteer,) was disabled by concussion of the brain while engaged on the lookout in the turret. Insensibility remained for about ten minutes, but the reaction following did not run high enough to require active treatment. Mr. Stodder's injury resulted from his knee coming in contact with the turret at the instant a heavy shot from the Merrimack

*Report to Gideon Wells, Secretary of the Navy.



Skipper of USS Monitor, John L. Worden

struck it. About ten minutes later Peter Trescott, seaman, was sent down from the turret suffering also from concussion of the brain. This injury did not result in total insensibility, but the circulation remaining depressed for some time, I administered stimulants in small quantities, watching carefully for reaction, and when it was established, controlled it successfully by cold affusion to the head. These were the only accidents that occurred until a percussion shell, near the close of the action, exploded against the lookout chink of the pilot-house, and resulted in severe injury to the eyes of Lieutenant Commanding John L. Worden, who was stationed there during the engagement. I made an examination, and succeeded in removing from the corneal conjunction some minute scales of iron and a small quantity of paint, forced by the exploding shell from the bars composing the pilot-house. He was injured also in a small degree from concussion, but this complication required no treatment. My further treatment of Captain Worden consisted entirely in making cold applications to his eyes, which was continued until, at the solicitations of his friends, Assistant Secretary of the Navy Fox and Lieutenant Wise, United States navy, he was removed from the Monitor to be taken to Washington. I am pleased to report that on the morning following the engagement, the injured parties remaining on board were ready and reported for duty.

I have the honor to be, &c.,

DANIEL C. LOGUE,
Acting Assistant Surgeon.

Following that fateful engagement between the ironclads in Hampton Roads, VA, LT Worden recovered his eyesight and went on to command the monitor USS Montauk. After the Civil War, he advanced to rear admiral, becoming superintendent of the Naval Academy in 1869.

Dr. Logue resigned from the Navy in October 1862.

The Budgetary Imperative

CDR R.A. Morin, MSC, USN

The medical bureaucrat is often seen as a set upon, beleaguered idealist who must try to sail the best tack across the winds of the professional world and the furies of the organizational world. (1) Scientists and other professionals, particularly the physician manager, must be exposed to and must develop an understanding of the inherent differences in the mores of these worlds.

Medical bureaucrats are not alone in this navigational plight. Hart and Scott (2) argue that there are imperatives that rule all who participate in organizational life, and these imperatives require strict adherence to certain administrative norms and behaviors. To them, the "organizational imperative" is a compelling and capturing paradigm which has supplanted individual values. It is this approach that serves as the theme for a similar concept—"the budgetary imperative."

Navy Medical Department officers, especially those whose orientation has been with civilian health care institutions, have special difficulty in weathering a double adjustment—that of military life and military organization.

Civilian health care institutions, programs, and organizations are often randomly conceived, (3) loosely defined, and organizationally malfunctioning. (4) Many civilian organizations have evolved as a result of the social interaction of an aggregation of physicians who deliver inpatient service as an extension of their private

or group practice and programs designed to provide health care delivery. Many civilian health care organizations are specifically designed to accommodate individual preferences and demands. (5) Civilian hospitals are often the antithesis of naval organizations.

The Navy Medical Department differs significantly from the civilian community in providing health care. The Navy Medical Department is an organized system of health care delivery. As such, its resources include people and programs, professionals and administrators, all of whom are deliberately organized for the pursuit of the common objective—the delivery of health care. These programs, their managers, and the clinicians and administrators are more than an aggregation of programs and people.

First, the Navy Medical Department is an integral part of a larger total Navy organization. Secondly, as Navy medical commands and departments individually fulfill missions and perform functions, they also are part of a larger system. Thirdly, the total Navy organization, which includes the Medical Department is itself deliberately designed and governed by rational design. Finally, and most importantly, the design and the governing rationale which describe and prescribe organizational relationships, roles, and behavior are traditional and unique to the Navy. Moreover, they have stood the test of time.

Navy health care delivery is by and large, managed by Medical Department officers who possess high professional skills and who exhibit a

wide range of personal values. Yet to achieve the goals of the Navy Medical Department, they must observe and be guided by the budgetary imperative.

The budgetary imperative is based on two assumptions and three rules:

Assumption I

Whatever resources are necessary for health care delivery can be achieved only by careful and successful budgeting.

Assumption II

All organization behavior must be such that it enhances the budget.

These precepts lead to three rules for managerial behavior. The following rules apply to all managers in the Navy Medical Department. All members:

- must be rational;
- must be effective managers; and
- must behave pragmatically.

The rule of rationality is the fundamental guideline for all managerial orientation regarding health care delivery services. This rationality is neither the philosophic nor the Hippocratic tradition of the health care deliverers. It rather refers to the rationality of budgetary execution, which is always the requirement to economize means to achieve ends. Emotionalism in proposals based on normative values are excluded from this rationality. The task for Medical Department managers is to adjust the relative values of resource inputs, to increase the value of efficiency, and to increase workload outputs. The value of efficiency must be main-

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tained along with its behavioral implications; otherwise, the Medical Department will be unable to achieve its objectives.

Effective management, as required by the budgetary imperative, is related to management of the immediate. Practically, commanding officers, chiefs of services, and all Medical Department officers must manage the immediate affairs of their areas of concern and, in doing so, they must learn to obtain and to husband resources. Medical Department professionals cannot rely on the comptroller, budget experts, or other administrators to obtain and husband these resources, nor can they lay the blame on these members when budgetary execution goes awry. The effective management of resources is the responsibility of all Medical Department personnel.

The final rule—pragmatism—will allow the Medical Department not only to promote a healthy budget but

to remain healthy in a challenging and changing environment. The rules of budgetary pragmatism require expedient behavior guided by the budgetary imperative; beyond this the rule for pragmatic behavior has no other moral or normative content. All members must be aware of the need to deal with problems expediently and practically.

If the budgetary imperative is to become more useful, Medical Department managers have two tasks. One must:

- realize the budgetary implications in all endeavors and understand that resource achievements will best be a result of expert budgeting, and
- learn to communicate with the practitioners of budgeting.

These provisions do not mean that the budgeteers will decide via the budgeting system what health care delivery values will prevail, but rather that the budget experts must

be governed by budgetary rationale and pragmatism in achieving health care delivery goals. They then must use their expertise to translate health care goals into meaningful budget language in which rationality (efficiency), pragmatism (budgetary behavior), and management (budgetary behavior) are clearly visible and measurable.

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Navy Aids Island Hospital

Dr. Cesar Calderon of the Vieques Memorial Hospital and Vieques Mayor Carlos Castano, accept a sample of the more than 12,000 pounds of medical supplies donated by the Navy to the small Caribbean island in a project termed "Operation Christmas."

Navy officials in Norfolk, including CAPT Richard S. Fitzgerald, COMNAVAIRLANT Reserve liaison officer (center), compiled the materials from stores of Project Handclasp materials in a joint effort made by civilians, the Navy, and Naval Reserve to help the Vieques community.

The supplies included hospital beds, examining lights, a heart resuscitation machine, respirators, weight scales, 1,000 pounds of linen, and nearly 800 pounds of medicine, ranging from antiseptics to penicillin. Accompanying the materials on the 6-hour flight from Norfolk were two civilian medical technicians who assisted Vieques doctors in assembling and setting up the equipment.



Photo by PHANI E. Lewis



Students, a first-year NCI fellow, and Head Nurse of the Medical Oncology ward make their daily rounds.

Cancer Treatment

A Unique Military-Civilian Program Underway

For several months now, the National Naval Medical Center (NNMC) and the National Cancer Institute (NCI) of the National Institutes of Health have been pooling their resources for the study and treatment of cancer. This unique military-civilian cooperation, far-reaching in scope, involves patient treatment, training of physicians and nurses, and advanced laboratory research.

Because NNMC and NCI are neighbors, a stone's throw from each other across Rockville Pike in suburban Bethesda, MD, their newfound affiliation seems quite natural, according to CDR Stephen Veach, MC, head of NNMC's Medical Oncology Branch and the project officer for the program. Each partner has unique qualities to bring to the relationship.

NCI is the nation's leading federally funded research organization charged with developing new means for the diagnosis and treatment of cancer. It has a large budget, modern laboratories, and a staff boasting some of the world's leading oncologists and oncology researchers.*

NNMC provides clinical care to active duty and secondarily to dependents and retired personnel. Its reputation as one of the military's major cancer referral centers on the East Coast gives it something NCI does not have in large numbers—patients.

The idea evolved that NCI's physicians could benefit from contact with

NNMC's large patient population—cases they would not ordinarily get to see. Moreover, it was hoped that some of these patients would agree to enter into clinical cancer treatment protocols and NCI's research studies on new cancer treatments would therefore flourish. As for the NNMC patients participating in the program, they would have access to NCI's specialists and would receive the best possible treatment available.

Once basic principles were agreed upon, conferees drew up a working agreement in which billets were identified, budgets evaluated, and architectural plans for lab and clinical facilities established. In 1979 the Director of NIH, the Director of NCI, the Surgeon General of the Navy, and NNMC's commanding officer signed

*Oncology is the study of the behavior and treatment of malignant diseases.

a memorandum of understanding governing the program. It is hoped that a formal interagency agreement will be signed soon.

What are the signatories' responsibilities? The Navy funds the military side of the program, but NCI is responsible for the new laboratory being renovated in the NNMTC Tower complex and for paying its own personnel. It is also contributing some nurses to the NNMTC oncology ward and research nurses to the clinic for protocol purposes and to administer chemotherapy to Navy and NCI patients. NCI also agreed to provide up to seven senior staff physicians and a variety of other support personnel, including lab technicians, research lab personnel, and salaries to support them. The total number of NCI billets applied to the NCI-Navy Medical Oncology Branch is 54, including oncologists, hematologists, radiation therapists, surgeons, corpsmen, nurses, and outpatient clinical receptionists.

NNMTC's inpatient and outpatient treatment facilities were made available such as a 30-bed ward designated for oncology patients and surgical, hematologic, and radiation therapy services. And, of course, NNMTC would provide the bulk of the patients.

Fellows

The program's central element is the oncology training of both civilian fellows and their Navy counterparts. Who are the fellows? The civilians who take part in the 3-year program have all been trained in internal medicine and are board eligible or certified. Some have been in private practice. All have had internships and residencies and come to the program with from 3 to 5 years of training. Presently, there are five NCI fellows and two Navy fellows in their first year.

This first year may be the most demanding. Each fellow becomes the primary physician for between 125 and 150 patients. In addition, they

will see consultations on other NNMTC wards, exposing them to as many as a thousand patients, far more than they would ever have access to at the NCI clinical center. As they become familiar with many manifestations of cancer, they add to their growing expertise.

Interspersed with patient treatment, the fellows' formal training includes participation in conferences and lectures both at NCI and NNMTC.

The NCI fellows spend the second and third years in the research laboratory and see patients only as they may relate to their specialized research studies.

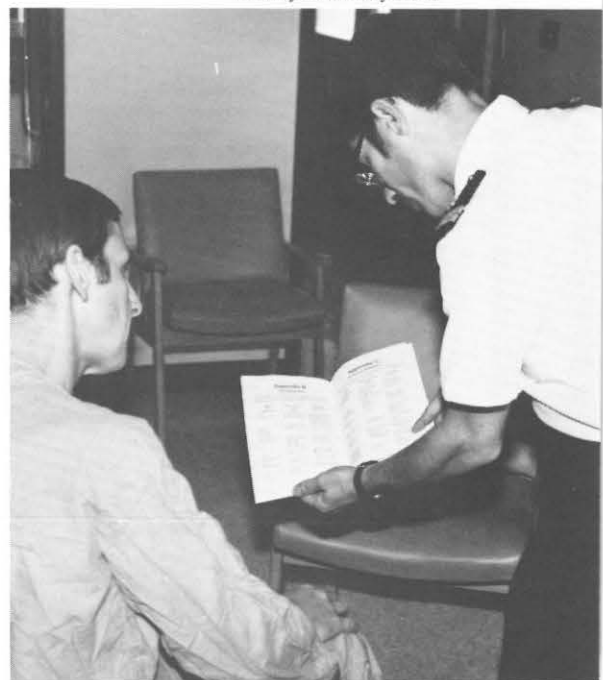
The Navy fellows, who are also either board certified or board eligible internists, do 3 years of clinical work, although they may arrange to spend some of this time in the lab. After completing 2 years of this oncology training, they are

Photo by HM3 Bobby Brown



Discharge planning by the nursing staff, a nutritionist, and a social worker is an early morning activity on the oncology ward. (Left to right): LCDR Judy Brinckerhoff, LT Ron Fraley, LTJG Marcella McCormack, Sandra Deutch, and Deborah Trush.

Photo by HM3 Bobby Brown



LT Ron Fraley, NC, instructs a patient on the use of drugs he will be receiving.



Photo by HMI Dave Diamond

Laser technology is used in the NCI-NNMC research laboratory to evaluate a cell's DNA content.



Photo by HMI Dave Diamond

Under a vertical laminar flow hood, lab technician Alfreda Simmons removes tissue from a laboratory mouse. The human adenocarcinoma that had been implanted will be minced and cultured for further study.

eligible to take the specialty examinations in either medical oncology or medical hematology. Their civilian counterparts may take the exam in medical oncology, the field all the NCI fellows concentrate on.

Patients

From the cancer patient's perspective, the care offered by the NCI-NNMC program cannot be duplicated elsewhere. He or she is assigned a fellow as their primary physician for the duration of the study, enabling a continuity of care on both an inpatient and/or outpatient basis. Then after a thorough medical evaluation, a clinical protocol is set up. The question may first be asked: What is the treatment of choice? Is treatment A preferable to treatment B? Treatment B may be the accepted treatment throughout the country, but new developments indicate that treatment A shows exciting prospects.

The compilation of a lengthy document follows, including scientific justification for the new treatment. By Federal law, the protocol must be passed by several human experimentation review committees, in this case both at NCI and NNMC. The patient is then brought into the process. The disease and its symptoms are thoroughly explained and two treatment plans may then be presented with the risks and benefits of each. Would the patient be interested in participating in a trial program? If so, they will have to sign an informed consent agreement with the knowledge that they can withdraw from the study at any time. According to Dr. John Minna, the program's civilian coordinator, this protocol system provides for a well-structured patient treatment program. "Since the patients now know beforehand what their treatment will be and what drugs they will have to take, it's made everyone happier," says LCDR Judy Brinkerhoff, NC, head nurse of the Medical Oncology ward.

The cancer treatment that follows may involve surgery, radiation



Photo by HM3 Bobby Brown

LT Fraley administers chemotherapy to a patient as HN Robert Williams looks on.

therapy, chemotherapy, and a host of supporting elements such as counseling and nutritional instruction. The nursing staff handles much of this support. The program's founders, in recognizing the special role the nurses would play in the overall treatment, established a course that deals specifically with the administration of chemotherapy, counseling, nutrition, and supervision of cancer patients.

Research

The NCI-NNMC research program is a modern and active one, and work is currently being performed in the temporary laboratories at the Veterans Administration Hospital in Washington, DC, until the new quarters open in the NNMC Tower complex next month. One leading study concerns small cell cancer of

the lung. In the past, lung cancer has been difficult to treat and the long-term survival rate has not been high because diagnosis usually comes after the disease has spread. The NCI-NNMC researchers are trying to develop an early diagnostic test for the disease and turn those statistics around.

Besides being a world leader in making monoclonal antibodies that may be useful in the treatment of many forms of cancer, the lab is studying mycosis fungoides, a rare skin disorder.

The hormonal manipulation of cells is another focus of attention. With prostate and breast cancer, hormone therapy can sometimes bring dramatic results without the side effects many cancer drugs bring on. The idea that lung cancer itself might also be treated by hormone manipulation

is one the lab's scientists are very excited about.

The ongoing merger of talent and resources by NCI and NNMC for both the clinical treatment of patients and for the conduct of a dynamic research effort is demonstrating what inter-agency cooperation can accomplish. Everyone benefits from such efforts—the fellows, the patients, the National Cancer Institute, the Navy, and all who pray that someday in the not too distant future, the war against cancer will be won. —JKH

For more information on the program, contact CDR Stephen Veach, MC, USN, at Commercial (202) 295-0495, Autovon 295-0495. Applications for military fellowships may be obtained from the Naval Health Sciences Education and Training Command, Bethesda, MD 20814. □

Pitfalls of Maternal Overprotection

CDR Eli Breger, MC, USNR

"Love rules without a sword, and binds without a cord." Fry

We know that parental attitudes greatly affect a child's personality development in a strengthening, weakening, or otherwise influencing manner. There are many levels of interaction between parent and child. In this essay we focus on the quality and intensity of maternal involvement in her growing child's life.

A mother's attitudes vary considerably from child to child despite superficial similarities. These differences, coupled with the individual makeup of the child, create a uniqueness such that no two relationships are the same. A mother's role reflects a mixture of many issues, past and present, conscious and unconscious. However, one generality stands out. Excessive maternal involvement is most likely to occur with the earliest born children, especially the first child. A new mother understandably lacks experience regarding appropriate extents of protection. She is likely to be overly identified with her first child who then serves psychologically as an extension of her self-

concept. The mother's role in over involvement is very important as she is usually the one who nurtures the child. However, the father's role is not insignificant either actively through what he does or passively through what he doesn't do.

Roots of Maternal Overprotection

Which women are likely to become overprotective mothers? There appear to be those with an excessive maternal drive based on deep biologic and hormonal issues correlating with strength, duration, and intensity of the menstrual flow. Such women are emotionally healthy and have had healthy life experiences.

In other mothers overprotection is a response to realistic life factors which excessively enhance the child's importance or increase her anxiety and insecurity about him. He may have come late in the reproductive life of the mother, who married at an advanced age or following repeated miscarriages. His birth may have followed upon the death of a sibling or other family member. Quite commonly a child is conceived in an attempt to strengthen an incompatible and crumbling marriage.

Children who have shown illness or handicap are understandably more likely to be overprotected.

There is the mother who overprotects because she had a deprived and affectionless childhood. By excessively sharing in the life of her child

she attempts to capture the pleasurable experiences she lacked in her own.

A mother may impose her own interests and attempt to realize her own unfulfilled goals through the life of her child.

Much overprotection emerges in women who are guilt-ridden about feelings of rejection or hostility toward their children. They tend to ease their guilt through over involvement.

Mother's Pattern

Maternal overprotection is the most common imbalance of involvement with the child. Conceptually, we may view it as one end of a continuum, the center of which is "normal involvement" with the other end being "maternal rejection." Overprotective mothers are also described as "overly close" or "hovering."

The child-mother relationship is characterized by an excessive maternal presence and an exaggerated and intense devotion to feeding, dressing, and bathing. Weaning is long delayed. Sleeping with the child is common.

An overly protective mother discourages age-appropriate activities viewing them as hazardous to her child's health and safety. She will watch him through the window to see that all goes well in his play. She may accompany him to school to shelter

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him against possible harm. Training toward appropriate social behavior tends to be rather permissive.

Overprotection results in a retardation of the development of independence and social maturity. The emotional umbilical cord remains uncut.

The Child's Pattern

Overprotected children gradually develop personalities characterized by immaturity. They demonstrate difficulty in relating with their peers and prefer adult company. Their level of confidence is low. They are submissive and avoid aggressive and athletic undertakings. These youngsters handle frustration with difficulty and are prone toward whining and temper tantrums. Underlying fears cause them to be anxious and restless. Curiosity concerning the world around them is diminished.

In time this defective development becomes apparent to the parents who communicate this to their child. The child senses their disappointment

and often responds by seeking even more affection and attention to offset his feelings of being rejected.

Outcome

The outlook is generally good with time and the child's increasing age, especially if the maternal contributions to the problem are not of a deep and disturbed type. Life normally brings with it increased opportunities for child-maternal separation such as school, peers, and clubs. Additionally, mothers tend to tire of a role that becomes increasingly burdensome and counterproductive to the development they would like to see. With time maternal prominence lessens and fathers traditionally increase their own roles. There are families in which this pattern continues leading to a persistent character problem.

Advice

To parents eager to help themselves and their children, I would

suggest the following. Prevention is most important. One should remain vigilant and be aware of early signs of overprotection in oneself or one's spouse. This is particularly necessary when the dynamics and personalities of the family and child show proper inclination for its development. Father's role in family life should be encouraged. He should actively participate in issues of authority as well as in other plans and decisions regarding his child.

The mother inclined to overprotection is often helped by motivating herself toward involvement in activities outside the home. This helps her achieve greater individuation and separation from the child as well as self-fulfillment.

In my experience, encouraging the child's participation in outside activities such as camp or clubs has proven most helpful.

"Who love too much hate in the same extreme." Pope □

Perceptions of a Hospital Corpsman

He is the guy next door, with his own dreams and problems of man. He is in heart, the young boy who never outgrew the rush and feeling of excitement when he restored life to the fallen baby sparrow or the injured pup.

Though not so different from you or I, he seemingly stands alone. For through his eyes, the destruction and brutality of war are the living nightmare his memory recalls.

In peacetime, the tragedy continues; for there in his arms, he's held the lifeless child.

The corpsman is a special one, yet humble in his ways. His care reaches out to all who "need."

To the suffering, he provides comfort; to those who await surgery, he instills confidence and hope. To the alcoholic, he helps to restore self-worth, and to the dying, he is the ear of a friend that listens.

But most importantly, the corpsman is the outstretched hand that through a single touch radiates care and love for mankind.

HM2 Lawrence A. Griffin
USS *Barry* (DD-933)

Nurse Corps Continuing Education

CAPT Mary A. Bogdanski, NC, USN

HM1 Polly A. Wells, USN

Continuing education was never like this! Besides, what is a topic like Operational Readiness Training doing in the Nurse Corps side of the house? Well, "the times they are a changin'" and so are we. Operational readiness training is an initial step toward preparing nurses to do their jobs should they suddenly be called upon to meet contingency or mobilization requirements. This emphasis

has long been missing from Nurse Corps training.

The first Operational Readiness Training Course conducted 21-25 Sept 1981 was developed by the Naval Health Sciences Education and Training Command (HSETC) to provide Nurse Corps officers with the knowledge and skills necessary to meet casualty care requirements. The major emphasis was on the nursing management of combat casualties and the preparation of Nurse Corps officers to function in readiness training roles at their respective commands. Graduates of this course will assume collateral responsibilities as Operational Readiness Training Officers and will establish training programs for other Nurse Corps officers and, eventually, hospital corpsmen in order to better prepare them for future operational assignments.

The primary objective of the course was to provide current information related to:

- the role of Medical Department personnel in meeting contingency

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RADM Shea addresses the group.



Participants learn and perform airway management techniques.

and mobilization requirements;

- medical readiness training initiatives within the Navy Medical Department;
- the organization and support role of Medical Department personnel within the fleet and field environments;
- the concepts of chemical, biological, and radiological (CBR) warfare;
- the description and use of personal protective measures in the CBR environment;
- the management of casualties suffered as a result of CBR warfare;
- techniques of airway management;
- the initial management and principles of care for burn casualties;
- the conditions, illnesses, and injuries of casualties suffered due to severe climatic conditions of cold and hot environments;



Participants observe various personal protective measures before practical session.



LCDR A. DePrima leads discussion on triage management.

- the care of casualties resulting from combat stress-related disorders; and
- the principles of triage and triage protocols.

To care for the kinds of wounds that may be inflicted in combat, it is necessary to understand some of the basic technological principles of the weapons that may be used on future battlefields and the wounding capabilities of those weapons.

Traditionally, Nurse Corps officers have been responsible for the teaching and training of Hospital Corps personnel. The Operational Readiness Training Course provides valuable insights into the duties and responsibilities of hospital corpsmen assigned aboard ship or with the Fleet Marine Forces.

Given that working knowledge as background, Nurse Corps officers are better equipped to examine and update current teaching and learning goals in order to insure that nurses and corpsmen are better prepared and can more effectively fulfill their roles as health care providers for the operational forces.

The course included both didactic and practical instruction. The speakers, experts in their fields, covered such topics as the management of burn casualties, the psychiatric casualty, chemical and radiation casualties, and casualties resulting from exposure to extreme (hot/cold) climatic conditions.

The practical sessions were designed to facilitate skills. Some were clinical skills familiar to the workaday world of nursing, such as the management of an obstructed airway. But many were new skills, an introduction to what one may be faced with in providing care to combat casualties in the future.

Particular emphasis was placed on the initial assessment of casualties



Group participates in triage decisions

presenting with multiple trauma and/or combined injuries suffered as a result of exposure to radiation or chemical agents.

Another segment of the course dealt with triage principles. Given the constraints of manpower, supplies, space, and other variables that affect the handling of large numbers of casualties, several scenarios were created to test one's practical skill in managing a surge of casualties. This thought-provoking and clinically challenging session was one of the highlights of the course.

Other practical time was devoted to chemical warfare defense and personal protective measures, as well as decontamination procedures for both radiation and chemically contaminated casualties.

All presentations placed an emphasis on the nursing responsibilities of providing care to the sick and

wounded in the modern battle theater and the teaching and training of Hospital Corps personnel.

RADM Frances T. Shea, Director, Navy Nurse Corps, addressed the group on topics of major interest to the individual participants. She stated that one of the primary goals of the Surgeon General is medical readiness and that "the Nurse Corps is relying on your personal and professional commitment in assisting to accomplish our goals to improve the overall readiness of the Navy Medical Department in the event of mobilization."

Based on the enthusiastic response and overall outstanding evaluation the course received, operational readiness training is perceived as an essential and vital component of Nurse Corps training programs. Planning for similar training courses in FY82 is in progress. □

Clinical Diagnosis and Treatment of Stomatitis

CDR G.M. Taybos, DC, USN

CDR G.T. Terezhalmay, DC, USN

Stomatitis is inflammation and ulceration of the oral mucosa due to local or systemic factors.

Diagnosis

The degree of mucosal involvement in stomatitis varies greatly depending upon the predisposing and precipitating factors. The clinical signs may range from discrete ulcerations to generalized erythematous or pseudomembranous involvement of the tissues. The ulceration is associated with mild-to-moderate pain, and there is the potential for secondary bacterial and fungal infections.

Some of the most common factors producing stomatitis include aspirin used as a local obtundent, pizza burns, excessive smoking, accidental aspiration of gasoline, and denture-related problems.

The aspirin tablet or the hot pizza will cauterize the tissues, causing a white, sloughing epithelial layer that leaves a raw, bleeding, painful surface (Figure 1). Heat and chemical irritants produced by excessive smoking cause erythema of the hard palate and a consequent grayish-white, thickened papular appearance with small red spots representing the dilated or occluded orifices of minor salivary glands (Figure 2). Gasoline and similar agents may induce small bullae or generalized swelling of all

tissues contacted. Ill-fitting removable dental prostheses may traumatize the oral mucosa, producing erythema, erosion, ulceration, or predisposing to chronic erosive candidiasis (Figure 3). The prostheses may also cause chemical or thermal burns, and the acrylic resin and its monomers may provoke an allergic reaction. Diabetes mellitus may also produce symptoms of stomatitis due to vascular changes, and in patients with removable dental prostheses, this response may be exaggerated.

Perhaps the most dramatic form of stomatitis is seen in the response of the oral tissues to radiotherapy and chemotherapy (Figure 4). The therapeutic value of both these modalities lies in their ability to interfere with

the normal mitotic activity of rapidly dividing neoplastic cells. Of course, the rapidly dividing cells of the oral mucosa are also affected. The resulting large ulcerative lesions may have a critical effect on patients, making it difficult for patients to maintain an adequate nutritional intake and serving as portals for serious dissemination of infection.

Treatment

Patient education. Misguided individuals must be informed that the topical application of medicaments such as aspirin that are compounded for systemic use is ill-advised. The severity of nicotine stomatitis may be reduced and the regression of the lesions may be effected if the patient



FIGURE 1. Stomatitis caused by topical application of aspirin

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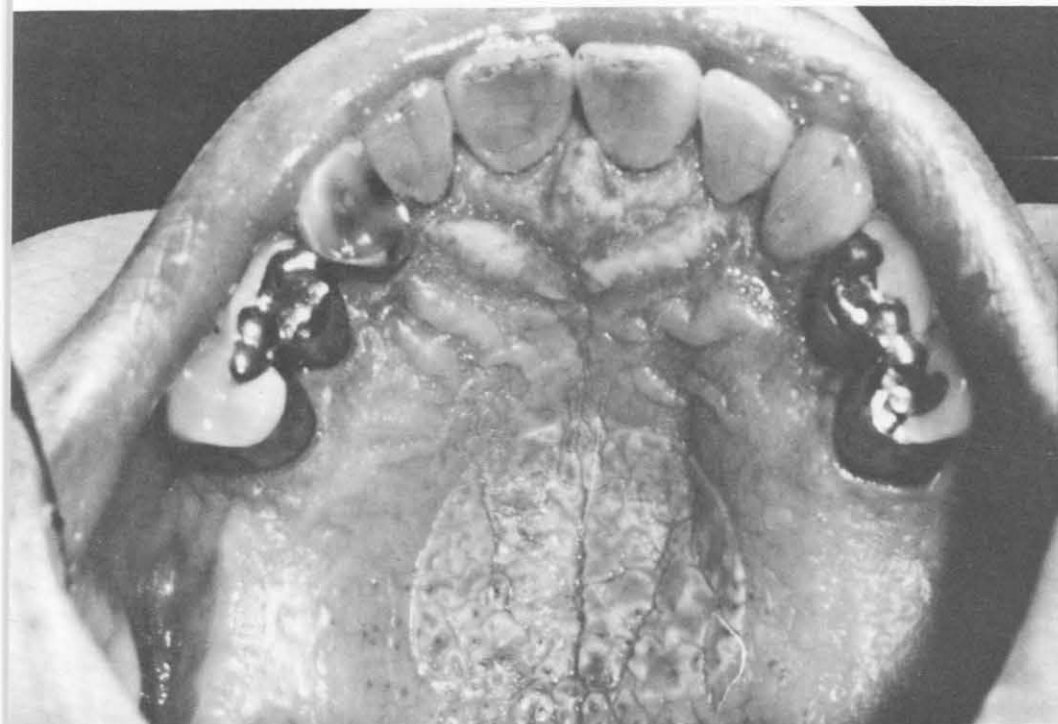


FIGURE 2. Stomatitis caused by excessive smoking



FIGURE 3. Stomatitis caused by an ill-fitting dental prosthesis

stops smoking. The use of troches containing vitamin A is seldom indicated. (1) Oral lesions associated with the aspiration of gasoline generally are not severe, although they may require supportive treatment, and complete healing usually occurs within 7 days. (2) The treatment of stomatitis caused by ill-fitting removable dental prostheses may require only minor denture adjustment—or complete refabrication of the prostheses. (3-10) The importance of meticulous oral hygiene cannot be overemphasized as an effective preventive and therapeutic modality in the management of stomatitis. (11)

Therapeutic regimen: small, isolated lesions. Such lesions respond well to the topical application of corticosteroids.

RX

Hydrocortisone acetate ointment, 0.5 percent

Disp: 5 gm tube

Sig: Apply to oral lesions after each meal and at bedtime.

Rx

Triamcinolone acetonide ointment, 0.1 percent

Disp: 5 gm tube

Sig: Apply to oral lesions after each meal and at bedtime.

Therapeutic regimen: severe stomatitis. The painful inflammatory response of the oral mucosa may be minimized if the patient uses a topical anesthetic and rinses with an alkaline-saline solution. Diphenhydramine hydrochloride elixir is the recommended topical anesthetic, (1,2) and it should be applied before meals and at bedtime. This agent is preferred to lidocaine hydrochloride viscous because it does not interfere with the pharyngeal phase of swallowing. Lidocaine hydrochloride can be used, but usually it should be diluted to one-third or one-half strength, especially when prescribed for young or debilitated patients. The patient should be advised to rinse

with the alkaline-saline solution after meals and at bedtime. Since candidiasis is a predictable sequela to stomatitis resulting from an altered flora, an antifungal agent, nystatin oral suspension, should be added to the regimen. (12-15)

Rx

Diphenhydramine hydrochloride elixer, 12.5 mg/5 ml
Disp: 4 oz bottle
Sig: Rinse with one tablespoonful before each meal and at bedtime.

Rx

Lidocaine hydrochloride viscous, 2 percent
Disp: 100 (450) ml bottle
Sig: Rinse with one tablespoonful before each meal and at bedtime. (Full strength or diluted to one-third or one-half strength).

Rx

Nystatin oral suspension, 100,000 units/ml
Disp: 60 ml bottle
Sig: Rinse with one teaspoonful 2 hours after eating and at bedtime; soak prostheses overnight.

Frequent rinses with the alkaline-saline solution provide considerable mechanical debridement. Some patients, however, have a lowered resistance to infection, especially patients with diabetes mellitus and those undergoing chemotherapy or radiotherapy. (13,14) Such patients should rinse with the alkaline-saline solution and with an oral antiseptic. Povidone-iodine may be prescribed as an oral antiseptic. (12)

Rx

Povidone-iodine mouthwash, 0.8 percent
Disp: 4 oz bottle
Sig: Rinse with one tablespoonful after meals and at bedtime.

Conclusion

The proposed therapeutic regimens for stomatitis are designed to achieve optimum patient comfort, insure adequate intake of nutrients, and minimize the possibility of serious dissemination of bacterial and fungal infections from the oral cavity.

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FIGURE 4. Stomatitis caused by radiotherapy

Endodontic Management of a Patient With Chronic Lymphocytic Leukemia (CLL)

CDR L. Ronald Martin, DC, USNR-R

COL Sigurds O. Krolls, DC, USAF (Ret.)

Leukemia may best be considered a neoplasm of the white blood cells. It is characterized by the appearance of abnormal immature white cells in the circulating blood, replacement of the bone marrow with leukemic cells, and widespread infiltration of the liver, spleen, and other tissues. Leukemia is analogous to metastatic dissemination of a solid tissue cancer. (1)

Leukemia may be classified on the basis of cell type (i.e., lymphocytic, myelogenous, or monocytic), the level of peripheral white count (i.e., leukemic or aleukemic), and the progression of the clinical course (i.e., acute or chronic). In general, chronic forms of leukemia have the highest white cell counts and the circulating white cells are more mature. The acute leukemias may have only moderate white cell counts (30,000-100,000/mm³), but the cells are more likely to be of the primitive "blast" form. (1)

Leukemia is a malignancy, which implies an excessive uncontrolled

proliferation of white cells affecting one of the various lymphocytic stem lines. Another theory is that the prolongation of the life of leukemic cells permits the abnormal accumulation of cells over a long period of time. (1,2,3)

Etiology

Chronic myelogenous leukemia is a bone marrow disease which originates in an abnormal line of granulocytic precursors; however, chronic lymphocytic leukemia does not. Therefore, it is believed that the abnormal marrow infiltrates may be easier to eliminate in CLL than in chronic myelogenous leukemia. Another theory proposes that development of CLL does not result from overproduction of cells, but from a defective system of removing them. The cells of CLL have biomechanical characteristics similar to normal cells, making selective chemical eradication of the leukemic portion very difficult. Therefore, aggressive chemotherapy is not used as in acute leukemia. In CLL there are no characteristic chromosomal abnormalities which make the accumulation-through-underdestruction hypothesis even more believable. Treatment, which is restricted until the patient is

symptomatic, is designed to induce gradual and minor adjustment to the white blood count and to enlarged lymph nodes and spleen. (2)

Although the cause of leukemia is unknown, four sets of influences are thought to be important: (1) ionizing radiation, (2) viruses, (3) chemicals, and (4) genetic predisposition. Radiologists seem to experience twice the incidence of leukemia found in the general population. Other toxic chemicals, such as benzol, have been associated with increased frequency of leukemia in humans. Leukemogenic viruses have also been demonstrated in rodents and farm animals. In humans, a genetic predisposition to leukemia, especially among close relatives such as identical twins, has been established. In spite of the mounting data pointing to the environment and genetic predisposition as the etiology of leukemia, in most of the leukemic cases no substantial evidence pointing to the cause can be identified. (1)

Diagnosis

The progressive accumulation of small lymphocytes in CLL and the fact that these cells have lost their ability to divide, along with the long life span of these metabolically

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abnormal cells, result in the total body lymphocyte mass slowly accumulating. The cells accumulate in the lymph nodes, spleen, blood, and bone marrow. Patients with CLL may go undiagnosed for years and are rarely diagnosed under age 30. Chronic leukemia is extremely rare in orientals. (3)

Diagnosis may be made serendipitously during a routine medical examination. The clinical symptoms include lethargy, hypermetabolism, and enlarged lymph nodes. The enlargement of neck may compress the trachea, resulting in breathing difficulties. Hemoglobin and platelet count may be normal at the time of diagnosis; however, anemia eventually develops as the disease progresses. Lymphocytosis usually precedes the rise in total white count. (2) Eventually, the white cell count may reach 100-500,000/ul, and over 90 percent are mature lymphocytes.

There are other disorders where lymph node enlargement is seen—lymphosarcoma and mononucleosis. High lymphocyte counts (50-100,000/ul) may be seen in the children with whooping cough or infectious lymphocytosis. (2)

Complications and Their Treatment

Anemia is a common complication of CLL. It is caused by a combination of red cell destruction and inadequate bone marrow compensation. Often the anemia fails to respond to the antileukemic therapy, and the patient may need to be transfused. Corticosteroids (prednesolone 10-20 mg four times daily) are usually prescribed until the remission of the anemia and then gradually with-

drawn. (2) Folic acid 1 mg daily may be used to control the anemia. Folic acid is a member of vitamin B complex, and it acts on megaloblastic bone marrow to produce normoblastic marrow. (4) In patients with severe hemolytic anemia and splenic sequestration of the red cells, a splenectomy is sometimes considered. (2)

A complication in CLL is abnormal bleeding which is usually due to thrombocytopenia as a result of the leukemia or the therapy. If chemotherapeutic agents are responsible for the thrombocytopenia, the marrow-depressing drugs are discontinued and corticosteroid therapy instituted until the marrow improves. (2)

Patients with CLL are also more susceptible to infection. Prophylactic antibiotic coverage, however, is not recommended and infections are treated with specific antibiotics. (2)

These patients are more prone to develop bronchogenic carcinoma, (9) peritonsillar abscesses, (10) and additional malignancies. (11)

Due to excessive chromosomal nucleic acids, synthesis as a result of lymphocytic proliferation and associated renal impairment, uric acid accumulation may result in gouty symptoms. Allopurinol is a xanthine oxidase inhibitor and may be given 200-300 mg daily orally to control the elevation of blood urates. (3)

Once the diagnosis is made, the patient may be followed for several years with little treatment. Therapy is not based on high white count alone. However, when anemia, thrombocytopenia, enlarged lymph nodes, splenomegaly, or invasion of the marrow or viscera occurs, therapy becomes necessary. (12)

If the nodes become large and restrict breathing, or splenomegally



FIGURE 1. Full maxillary denture, carious mandibular anterior teeth

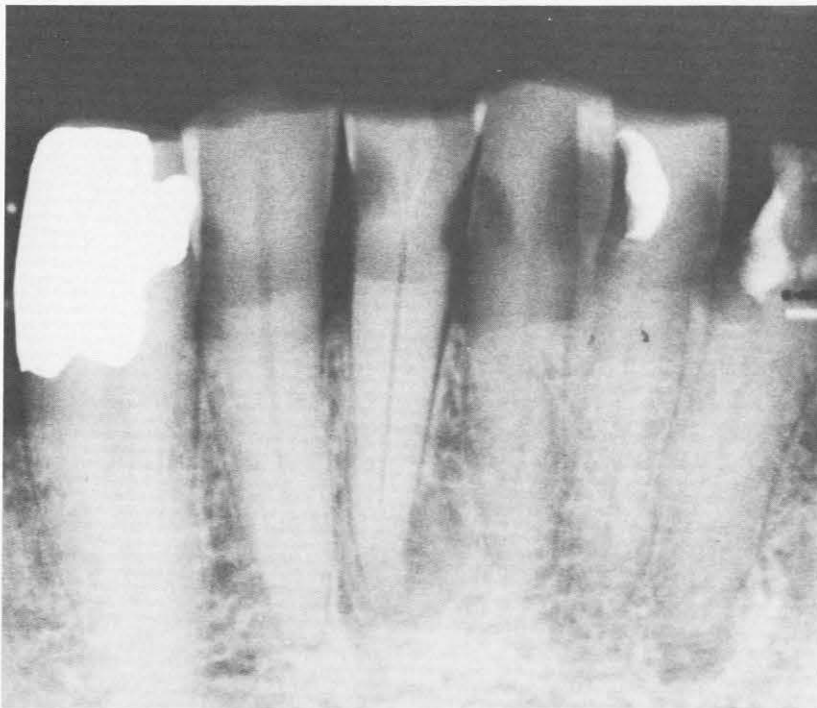


FIGURE 2. Periapical lesions, teeth 22 and 25, beginning x-ray

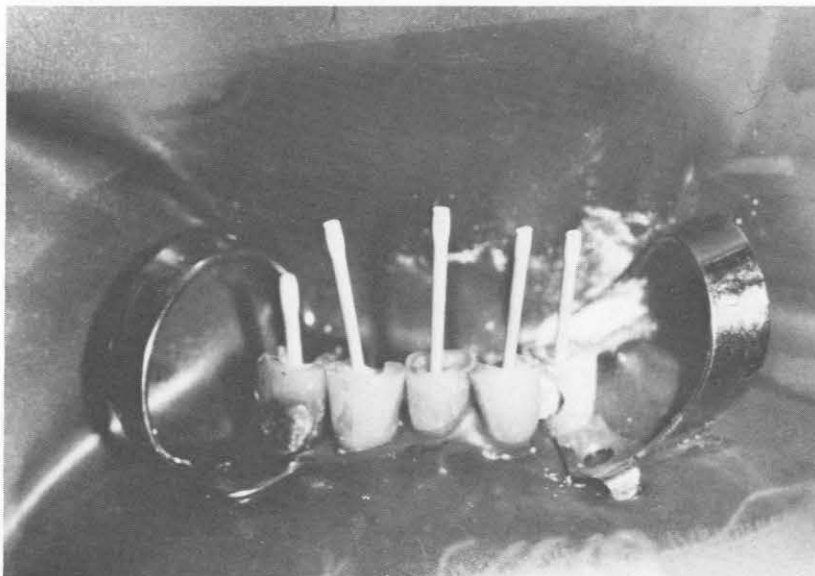


FIGURE 3. Fitting master cones before lateral condensation of gutta percha

causes compressive symptoms, chemotherapy and local irradiation may be employed. Alkylating agents, chlorambucil, or clophosphamide are used commonly. Chlorambucil is usually given .2 mg/kg of body weight orally, and the dosage is reduced as the white count falls. Finally, the patient may be maintained on 2 mg daily or every other day. (3,4,12)

It is somewhat discouraging to note that, although chemical agents and ionizing radiation may induce remission, little is known about the pathogenesis of the disease. It seems unlikely that much progress will be made in the management of CLL until more is known about the basic biologic metabolic activities of leukemic cells. (2)

Case Report

In 1973 a 77-year-old male patient was referred to us for endodontic therapy with the CLL initially diagnosed in 1970. Since that time medical management of the patient consisted mainly of monitoring the blood counts every 6 weeks. The patient was taking allopurinol (200 mg daily) to control the elevation of blood urates, and folic acid (1 mg daily) for the anemia that commonly develops during the course of CLL. White blood cell count at this time was 17,000.

The patient was referred for endodontic therapy to aid in the construction of a mandibular overdenture in lieu of extraction of the remaining six anterior teeth due to the medical complications and the increased stability that would be gained by the overdenture procedure.

Healing is usually slower when anything interferes with circulation, whether it is the lack of oxygen in the blood, poor vascularity due to age, anemia, hemophilia, or leukemia. Pulpless teeth in patients with blood dyscrasias are best treated by non-surgical endodontic treatment. Periapical healing may be slower but fewer complications arise when non-surgical root canal treatment is accomplished instead of extractions. (13)

The patient was wearing a full maxillary denture (Figure 1), and the remaining mandibular teeth (22, 23, 24, 25, 26, and 27) were broken down. During mastication of food the patient complained of pain on teeth #22 and 25. These same two teeth were sensitive to percussion and responded negatively to electric and thermal pulp tests. The remainder of the mandibular teeth responded normally to all pulp tests.

Radiographic examination (Figure 2) demonstrated periapical radiolucencies on teeth #22 and 25 and large carious lesions on 22, 23, 24, and 25. Leukemic infiltration of the pulp has been reported by Stanley. (14) However, this is usually more

common in acute leukemias.⁽¹⁵⁾ Although destructive lesions of bone are reported in some cases of chronic leukemia, resulting in pathogenic fracture or osteomyelitis,⁽¹⁶⁾ it was thought in this case that the lesions were typically odontogenic in origin. Patients who have acute leukemia may develop gingival hyperplasia, gingival bleeding, and gingival ulceration.^(15,17) Leukemias and other blood dyscrasias may eventually cause bone changes by pressure. Roentgenographic manifestations occur in both mandible and maxilla. In acute leukemia necrosis of the periodontal ligament and rapid loosening of the teeth are frequently evident.⁽¹⁷⁾ Extraction of the teeth may hasten the demise of the patient. Endodontic nonsurgical treatment reduces this risk.⁽¹⁷⁾

Clinical Findings

Most texts refer to lymph node, splenic enlargement, and gingival hyperplasia as symptoms in CLL.^(15, 16, 18) This patient had none of the classic symptoms.

Consultation with the patient's physician before treatment revealed no contraindication to nonsurgical endodontic therapy. The physician's only concern was the mandibular block. He asked that the number of blocks be kept to a minimum in order to prevent bleeding complications that might arise from severing vessels during the block. To minimize the risk, teeth on the right side were all fully instrumented at the first visit; at the second visit the teeth on the left side were fully instrumented.

At the first visit local anesthesia was obtained, and #27, 26, and 25 were instrumented and irrigated with 5 percent NaOCl. Cultures before and after treatment for #27 and #26 were negative. Tooth #25 was positive before treatment and negative after instrumentation.

At the second visit the patient reported no symptoms or complications from the previous visit. Anesthesia was again obtained, and teeth #22,

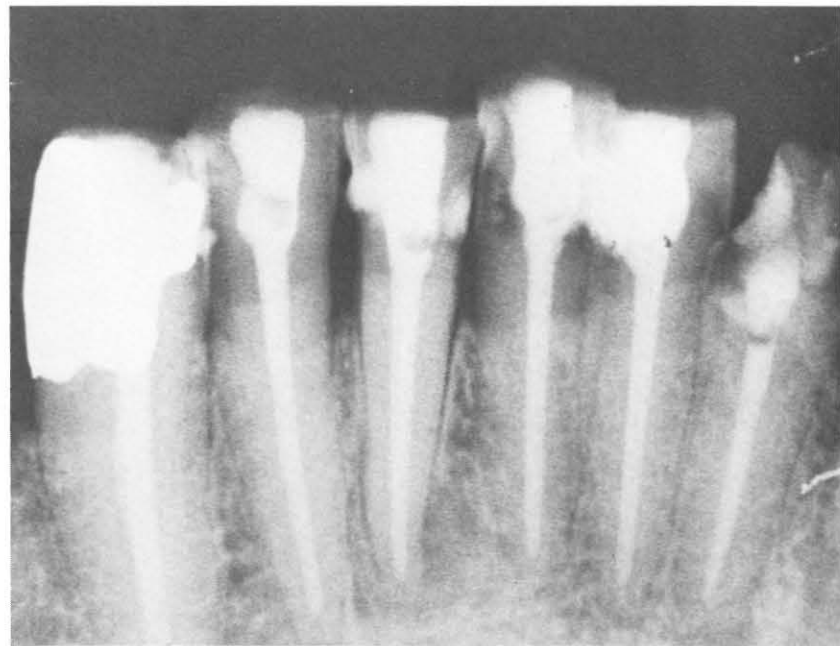


FIGURE 4. Completion of root canals

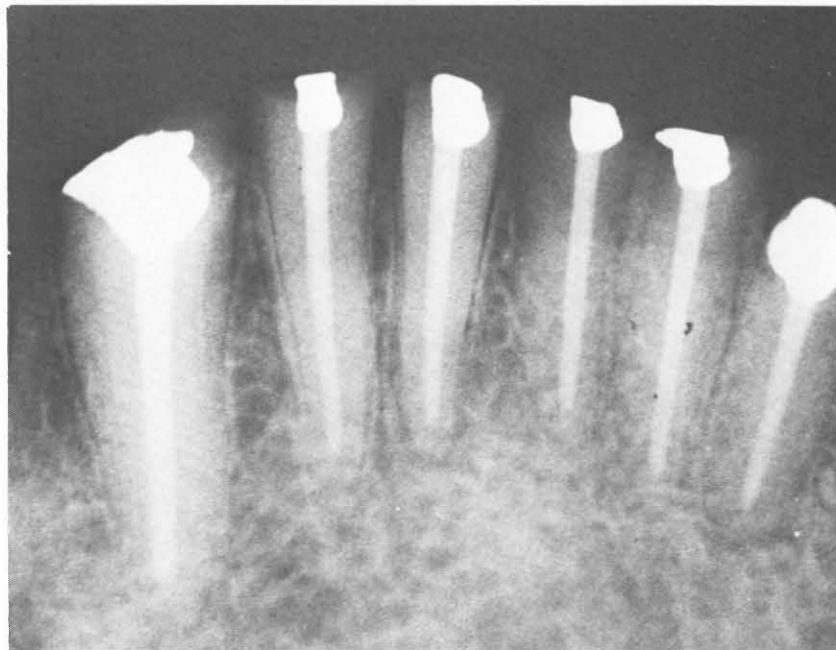


FIGURE 5. 1-year followup radiograph

23, and 24 were fully instrumented. As before, 5 percent NaOCl was the irrigant used. Cultures for #23 and 24 were negative before and after instrumentation, while the culture for #22 was positive before instrumentation and negative after.

At the third visit the patient reported no symptoms or complications. All the teeth were filled with

lateral condensation of gutta percha using Grossman's Sealer (Figures 3 and 4), and the patient was referred to prosthetics for final restoration and fabrication of the overdenture. Followup examination and radiographs at 12 months (Figure 5), 3 years, 2 months (Figure 6), 6 years, 7 months (Figure 7) demonstrate apparent healing of the periapical lesions on

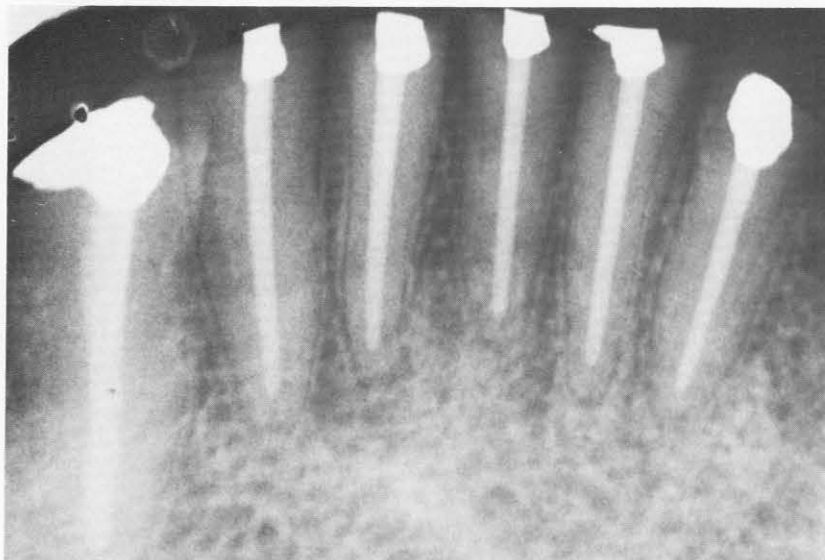


FIGURE 6. Followup radiograph, 3 years, 2 months

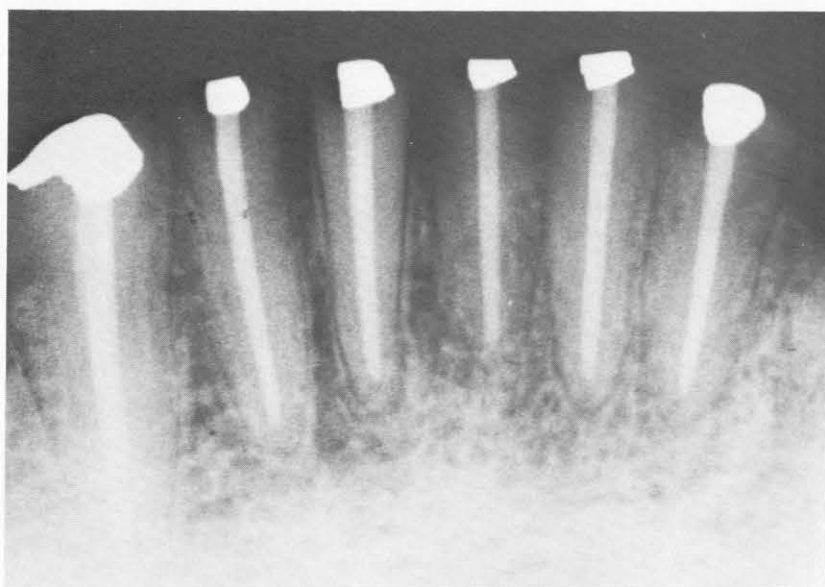


FIGURE 7. Followup radiograph, 6 years, 7 months

#22 and 25, and normal periodontal ligament space on all the teeth treated.

During the last 6 years since the endodontic therapy was completed, the patient has had one episode of elevated white count. The white count went up to 144,000 and, as a result, the patient was placed on 20 mg of chlorambucil every 2 weeks. This was continued for 7 months until the white count dropped to 17,000. At this writing, 8 months after the ele-

vated white count, the white count is 19,000 and the patient is taking no medication except for allopurinol (200 mg daily) and folic acid (1 mg daily).

This patient was 74 years of age when the diagnosis of chronic lymphocytic leukemia was made and 77 when the endodontic therapy was completed. In spite of his advanced age and systemic complications, endodontic therapy was successful, further indicating that endodontic therapy is not contraindicated in pa-

tients with advanced age or systemic disease that is under control. In fact, this case points out that whenever a patient has a medical complication that would present complications if surgical extractions were attempted, nonsurgical endodontics is the treatment of choice. (19)

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Notes & Announcements

CONFERENCE ON SEXUAL VICTIMIZATION OF CHILDREN

The Child Protection Center/Special Unit (CPC/SU) and the Office of Child Health Advocacy of Children's Hospital National Medical Center will sponsor the Second National Conference on Sexual Victimization of Children. The conference will be held 6-8 May 1982 at Stouffer's National Center Hotel, Arlington, VA.

The purpose of the conference is to bring together health care, social service, mental health, and law enforcement professionals who are currently working in programs designed to meet the needs of sexually abused children and their families. Conference participants will have an opportunity to learn about the newest treatment modalities, the latest research findings, and innovative methods of program development and funding. Since cases of child sexual abuse pose both health and legal problems, the conference will emphasize cooperation among the various disciplines and agencies involved.

The registration fee will be \$90.

For further information write: Mrs. Nathania A. Miles, Program Coordinator, Children's Hospital National Medical Center, 111 Michigan Ave., Washington, DC 20010 or call (202) 745-5682.

MEDICAL CONFERENCE AND TOUR

The Korean Medical Association of America and the Korean Medical Association are sponsoring a medical conference and tour 28-30 June 1982. The conference, in honor of 100 years of Korean-American relations, will be held at the Lotte Hotel in Seoul. A group tour will be arranged and will include travel, hotel, and a group discount.

For more information write: Dr. Suk S. Lee, Department of Radiology, Our Lady of Mercy Hospital, Dyer, IN 46311 or call (219) 322-8930.

SYMPOSIUM ON COMPUTER APPLICATIONS IN MEDICAL CARE

The Sixth Annual Symposium on Computer Applications in Medical Care will be held 30 Oct-2 Nov 1982 at the Sheraton Washington Hotel, Washington, DC.

The symposium is designed to inform physicians, health care administrators, biomedical scientists, engineers, and other health care professionals about current and potential applications of computer technology to health care and to identify areas of research and development that need to be addressed. Topic areas include medical applications, computer systems and techniques,

and demonstrated benefits.

Original papers and/or proposals for workshops and tutorials should be submitted no later than 15 March 1982. Papers accepted will be reviewed and published in the *Proceedings* of the symposium.

For further information write or call Bruce I. Blum, Symposium Program Chairman, Johns Hopkins University, Traylor 514, Baltimore, MD 21205, telephone (301) 955-8379; or SCAMC—Office of CME, 2300 K St., N.W., Washington, DC 20037, telephone (202) 676-4285.

SYMPOSIUM FOR TRAUMA PHYSICIANS AND ADMINISTRATORS

A Symposium for Trauma Physicians and Administrators will be held 19-21 April 1982 at the Hyatt Regency Hotel, Baltimore, MD.

The symposium has been approved for ACEP and AMA Category I continuing medical education credits.

The registration fee will be \$275 (\$300 after 12 March 1982).

For further information write Ginny Marks, Registrar, MIEMSS, 22 S. Greene St., Baltimore, MD 21201 or call (301) 528-6846.

INTERNAL MEDICINE RESIDENCY OPENING

An unexpected opening has occurred in the summer 1982 sessions of the GME-2 internal medicine residency program.

For information write or call CAPT M.E. Bohan, MC, USN, Chief of Medicine, Box 8605, Naval Regional Medical Center, Portsmouth, VA 23708. Autovon: 690-0111 (ask for 398-5067) or Commercial: (804) 398-5067.

WANTED—CLINICAL NOTES

U.S. Navy Medicine needs articles for the Clinical Notes section. Submissions should be no longer than 1,500 words, double-spaced, and if possible, contain references and black-and-white photos.

Physicians, dentists, and other practitioners should have manuscripts cleared for professional accuracy prior to submission.

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